

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18275

8299

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middlestown</i>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Edith</i>		First <i>Edith</i>	Middle <i>S.</i>	Last <i>Aha/TE</i>	4. DATE OF DEATH <i>August 20 1956</i>	Month <i>August</i>	Day <i>20</i>	Year <i>1956</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-26-1891</i>	9. AGE (In years last birthday) <i>65 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Edward M. L. Lighter</i>		14. MOTHER'S MAIDEN NAME <i>Jennie Sanner</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Russel Adalt, Middlestown Md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		DUE TO <i>Cerebral Hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>5 hrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i>		DUE TO (c) <i></i>							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>Aug 20, 1956</i> , to <i>Aug 20, 1956</i> , that I last saw the deceased alive on <i>Aug 20, 1956</i> , and that death occurred at <i>5:15 PM</i> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>J Elmer Harp</i>		M.D.		ADDRESS (Street, city or town, state) <i>Middlestown</i>		DATE SIGNED <i>8-21-56</i>			
PHYSICIAN'S NAME (Type) <i>J. Elmer HARP</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-23-56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rehomed Cemetery</i>		22d. LOCATION (City, town, or county) <i>Middlestown Md.</i>		(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladhill C. Middlestown Md.</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR <i>Elizabellie Heck</i>		24b. REGISTRAR'S SIGNATURE			
				DATE <i>24 Aug 1956</i>					

RECEIVED - COMMUNICATIONS SECTION - DEPARTMENT OF DEFENSE

BUREAU V. S.

JULY 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88276

CERTIFICATE OF DEATH

Reg. Dist. No. 131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewistown		c. LENGTH OF STAY IN 1b 35 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Elizabeth	Middle Bowers
4. DATE OF DEATH August 3 1956	Month Month	Day Day	Year Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18 1885
9. AGE (In years last birthday) 70	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Fred. Co. Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Daniel Pearl		14. MOTHER'S MAIDEN NAME Annie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Wilbert L. Bowers
		Address Lewistown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
DUE TO Cerebral hemorrhage			
INTERVAL BETWEEN ONSET AND DEATH 5 min.			
331X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension			
DUE TO (c) Arteriosclerosis			
?			
?			
?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic myocarditis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 2 1956 , to Aug. 3 1956 , that I last saw the deceased alive on Aug. 2 1956 , and that death occurred at 5:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Franklin Birely		ADDRESS (Street, city or town, state) Thurmont, Md. DATE SIGNED 8/4/56	
PHYSICIAN'S NAME (Type) Dr. M. Franklin Birely			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-56	22c. NAME OF CEMETERY OR CREMATORIUM Lewistown Cemetery
22d. LOCATION (City, town, or county) Lewistown Fred. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Prezger		24a. REC'D BY REGISTRAR Elizabeth B. Heeb	24b. REGISTRAR'S SIGNATURE
		DATE 6 Aug 1956	

CERTIFICATE OF DEATH

1956

BUREAU N.Y.

AUG 7 1956

RECEIVED

-3-

118277

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

8313

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick Rd # 2</i>		c. LENGTH OF STAY IN lb <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Rural Hopewell</i>		e. STREET ADDRESS Rural Hopewell	
3. NAME OF DECEASED (Type or print) <i>John Edward Carroll</i>		4. DATE OF DEATH <i>August 24 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 1-1881</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>74 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lime plant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>*****</i>	
11. BIRTHPLACE (State or foreign country) <i>Frederick, Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	

13. FATHER'S NAME

James H. Carroll

14. MOTHER'S MAIDEN NAME

Cecelia Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

214-10-1573

17. INFORMANT

Addie Carroll Hopewell Fred. Co. Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

331X

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

3 days

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour
a. m.
p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

B. O. Thomas

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

Aug. 25, 1957

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF
28 Aug. 1957

22c. NAME OF CEMETERY OR CREMATORIAL
Hopewell

22d. LOCATION (City, town, or county)
Frederick, Co. Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS
Charles E. Hicks III Frederick, Md.

24a. REC'D BY REGISTRAR

DATE *Aug 25, 1957*

24b. REGISTRAR'S SIGNATURE

DATE *Aug 25, 1957*

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours of death. If any delay is necessary, please excuse the certifying physician writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PMA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

UG 28 1956

REGELE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118278

8314

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville		c. LENGTH OF STAY IN 1b 9 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) Lucy			First Lucy	Middle Higbee	Last Corl				
4. DATE OF DEATH August 16, 1956		Month August	Day 16	Year 1956					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 26, 1908	9. AGE (In years lost birthday) 47 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife & School Teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Emmitsburg Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Elnathan Lewis Higbee			14. MOTHER'S MAIDEN NAME Mary Kilmer						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Rev Claude R. Corl, Sabillasville Md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) Hypertension Cardiac Vasculitis Disease DUE TO			INTERVAL BETWEEN ONSET AND DEATH 1 hour						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Blue Ridge Inn, Pa.		20f. (City or town) State College		(County) Centre Co.	(State) Pa.
21. I certify that I attended the deceased from July , 1956, to 16 Aug , 1956, that I last saw the deceased alive on 16 Aug , 1956, and that death occurred at 7:35 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert A. Plough, M.D.</i> ADDRESS (Street, city or town, state) <i>Blue Ridge Inn, Pa.</i> DATE SIGNED <i>16 Aug 56</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/56		22c. NAME OF CEMETERY OR CREMATORIAL Pine Hall		22d. LOCATION (City, town, or county) State College, Centre Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Y. Goss, Waynesboro Pa.</i>		ADDRESS <i>Waynesboro Pa.</i>		24a. REC'D BY REGISTRAR AUG 20 1956		24b. REGISTRAR'S SIGNATURE <i>Dr. J. B. Lyons</i>			

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MISSOURI STATE DEPARTMENT OF HIGHER EDUCATION

CERTIFICATE OF DEATH

DEATH

DEATH

BUREAU V. S.

AUG 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

108279

8300

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 16 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 217 South Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD		First E.	Middle CURRENS
4. DATE OF DEATH August 19		Last CURRENS	Month August
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 6, 1891		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner and Manager		10b. KIND OF BUSINESS OR INDUSTRY Cemetery	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Currens	
14. MOTHER'S MAIDEN NAME Ida H. Hoffman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 207-05-4878		17. INFORMANT Mrs. E.E. Currens - 217 S. Market St., Frederick,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 420.1		(b) Coronary Occlusion; sudden	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 10, 1956 to August 19, 1956 , that I last saw the deceased alive on August 16, 1956 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Md. DATE SIGNED H. J. Slusher M.D. 9 East Church Street, Frederick—8/20/56	
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Dr. H. J. Slusher	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Frederick Memorial Park
22d. LOCATION (City, town, or county) Frederick		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Clinton		24a. ADDRESS Frederick, Md.	24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck
VS A15 (4) 15M 9/55		DATE 21 Aug 1956	

STATE OF NEW YORK - VALUATION - 1956
CERTIFICATE OF DEATH

BUREAU X.

AUG 22 1956

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8315

CERTIFICATE OF DEATH

108280
Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent Home		e. STREET ADDRESS Libertytown	
3. NAME OF DECEASED (Type or print) FLORIDA		First FLORIDA	Middle VIRGINIA
		Last DAVIS	4. DATE OF DEATH August 22 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 9, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
10c. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Molesworth		14. MOTHER'S MAIDEN NAME Margaret Reinhart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
		17. INFORMANT Mrs. F. Sidney Hammond - Libertytown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exhalation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 month</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arterial</i>		DUE TO Cerebral Hemorrhage <i>6 month</i>	
DUE TO <i>Cardio-Vascular Renal Disease</i>		DUE TO <i>2 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 25, 1956 , to August 22, 1956 , that I last saw the deceased alive on Aug. 21, 1956 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 17 East Second Street - Frederick, Md.	
ACTUAL SIGNATURE <i>H. Lawrence Fahrney</i>	M.D.		DATE SIGNED <i>8-23-56</i>
PHYSICIAN'S NAME (Type) Dr. Lawrence Fahrney	17 East Second Street - Frederick, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 25, 1956	22c. NAME OF CEMETERY OR CREMATORIUM St. Peter's Cemetery	22d. LOCATION (City, town, or county) Libertytown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. Clinch, Son, Frederick, Md.</i>		24a. REC'D BY REGISTRAR DATE 24 Aug 1956	24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9901

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MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

8316

CERTIFICATE OF DEATH

18281

Reg. Dist. No.

144

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz	c. LENGTH OF STAY IN 1b Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Tracey H.	First	Middle DeLauter	4. DATE OF DEATH August 17 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1866
		9. AGE (In years lost birthday) 90 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY General farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George W. DeLauter	
14. MOTHER'S MAIDEN NAME Isabelle Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Sadie M. DeLauter Lantz, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Hemorrhage		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 15, 1954, to Aug. 16, 1956, that I last saw the deceased alive on Aug. 16, 1956, and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont, Md. DATE SIGNED 8/18/56			
ACTUAL SIGNATURE James K. Gray M.D.		PHYSICIAN'S NAME (Type) Dr. James K. Gray Thurmont, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-20-56	
22c. NAME OF CEMETERY OR CREMATORIAL Burns Hill Cemetery		22d. LOCATION (City, town, or county) Waynesboro (State) Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond J. Clegg Thurmont, Md.		24a. REC'D BY REGISTRAR AUG 21 1956	
		24b. REGISTRAR'S SIGNATURE J. H. Hendry	

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MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

18282

8317

CERTIFICATE OF DEATH

Reg. Dist. No.

147

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Mt. Airy		c. LENGTH OF STAY IN lb 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS Plane Four		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First LUTHER	Middle EDWARD	Last DERR	4. DATE OF DEATH AUG. 21, 1956	Month Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 1, 1882	9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker retired		10b. KIND OF BUSINESS OR INDUSTRY Bakery	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Cornelius Derr			14. MOTHER'S MAIDEN NAME Mary Metzer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 215-16-9274	17. INFORMANT Mrs. Mary C. Derr,	Address SAme	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1953 r. a. 1955 d. 1956			INTERVAL BETWEEN ONSET AND DEATH 1953-1955-1956		
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost. b. Interstitial pneumonitis and bronchitis, also laryngitis			DUE TO c.		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) (State) Frederick Co., Md.
21. I certify that I attended the deceased from 4/4/55 , 19 55 , to 8/5/56 , 19 56 , that I last saw the deceased alive on 8/1/56 , 19 56 , and that death occurred at 4 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>James P. Kerr</i>			ADDRESS (Street, city or town, state) 10 Maryland St., Frederick, Md.		
PHYSICIAN'S NAME (Type) JAMES P. KERR			DATE SIGNED 7-1-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-24-1956	22c. NAME OF CEMETERY, COLUMBIAN Marvin Chapel	22d. LOCATION (City, town, or county) Frederick Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,			ADDRESS Winfield, Md.	24. REC'D BY REGISTRAR AUG 23 1956	24b. REGISTRAR'S SIGNATURE <i>Mrs. Louise Lankley</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8301

CERTIFICATE OF DEATH

118283

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be rejoined to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. CEMETERY TOWN (If outside corporate limits, write RURAL and give nearest town) KNOCK ROCKY RIDGE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First BRIAN	Middle GERARD	Last ETHERIDGE	
4. DATE OF DEATH AUG. 8 1956	Month AUG.	Day 8	Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-56	
9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS Days 36	Hours 1	Min. 36
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.
				12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME RAYMOND ETLRIDGE Jr.		14. MOTHER'S MAIDEN NAME MARY RUTH WETZEL		Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple Congenital Anomalies				INTERVAL BETWEEN ONSET AND DEATH -
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-8 , 1956, to 8-8 , 1956, that I last saw the deceased alive on 8-8 , 1956, and that death occurred at 7:40 P.M. from the causes and on the date stated above.				
ACTUAL SIGNATURE Fred Heldrich Jr. M.D.				ADDRESS (Street, city or town, state) 220 N MARKET
				DATE SIGNED 11/8
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 9-1956		22b. DATE THEREOF Aug 9-1956		22c. NAME OF CEMETERY OR CREMATORIUM St Anthony Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Heldrich Jr. M.D.		ADDRESS Frederick		24a. LOCATION (City, town, or county) (State) MD
				24b. REC'D BY REGISTRAR DATE 9 Aug 1956
				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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8318

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN lb 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 707 North Market Street		
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Vindobona Convalescent & Rest Home				d. STREET ADDRESS 707 North Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES JACOB EVERHART		First	Middle	Last	4. DATE OF DEATH August 19, 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input checked="" type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Sept 1862	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Cigar Maker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George W. Everhart		14. MOTHER'S MAIDEN NAME Rachel Frankfrutter						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Dr. David G. Everhart, Jr. Frederick, Md.		Add 20 N. Court St., Frederick, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Golmecard Edema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Shows</i>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) <i>Arterio Sclerosis</i>		5 yrs +				
DUE TO (c) <i>Cardo-vascular</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from Aug. 19, 1956 , to Aug. 19, 1956 , that I last saw the deceased alive on Aug. 19, 1956 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D.		ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md.		DATE SIGNED 8/20/56		
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.								
22a. BURIAL, CREMATION, REBURN (Specify) Cremation		22b. DATE THEREOF 22 Aug 1956		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Crematory		22d. LOCATION (City, town, or county) Washington, D. C.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 20 Aug 1956		24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118285/31

CERTIFICATE OF DEATH

Reg. Dist. No. 212

8319

1. PLACE OF DEATH a. COUNTY <u>Frederick</u>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Braddock Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Braddock Heights</u>	
d. LENGTH OF STAY IN 1b <u>15 yrs</u>		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eileen</u>	First <u>C</u>	Middle <u>Fleischman</u>	4. DATE OF DEATH Month <u>Aug</u> Day <u>2</u> Year <u>1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11/21/1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George T Cubitt</u>		14. MOTHER'S MAIDEN NAME <u>Clara Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mr. J. Fleischman - Frederick, Md</u>	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>exhaustion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>rickets of liver</u> DUE TO <u>Acute</u> (c)		4 weeks	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Acute</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Frederick</u> (County) <u>Md</u> (State) <u>Md</u>	
21. I certify that I attended the deceased from <u>Aug 16</u> , 1956, to <u>Aug 2</u> , 1956, that I last saw the deceased alive on <u>Aug 2</u> , 1956, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Adalena Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>Frederick</u> DATE SIGNED <u>8/2/56</u>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/56</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) <u>Frederick</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Helton, Barnesville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>8/6/56</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Elisabeth W. Eli</u> <u>Elisabeth W. Eli</u> <u>Elisabeth W. Eli</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EUREAU V. S.

AUG 1962

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8320

CERTIFICATE OF DEATH

118286
39

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN lb 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
		William	Arthur	GARDNER		August	21	1956

5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1884	9. AGE (In years less birthday) 72 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Ass't.	10b. KIND OF BUSINESS OR INDUSTRY Victor Cullen Hos. Maryland	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME James Gardner	14. MOTHER'S MAIDEN NAME Rosa Ammy
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. No 726-05-3631	17. INFORMANT Donald J. Gardner Cullen, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)	Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 months
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	(b)	Arteriosclerotic Cardiovascular Disease & years	
	(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I attended the deceased from July 16, 1956 to Aug. 21, 1956, that I last saw the deceased alive on Aug. 20, 1956, and that death occurred at 10:55 A.M. from the causes and on the date stated above.						
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ACTUAL SIGNATURE *Robert A. Kiefer* ADDRESS (Street, city or town, state) *Blue Ridge Cemetery, Thurmont, Md.* DATE SIGNED *Aug. 26, 1956*

PHYSICIAN'S NAME (Type)	Dr. Robert A. Kiefer
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-24-56	22c. NAME OF CEMETERY OR CREMATORIUM Blue Ridge Cemetery	22d. LOCATION (City, town, or county) Thurmont	(State) Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond L. Clegg</i>	ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR F.I.G. 241956	24b. REGISTRAR'S SIGNATURE <i>J. B. Lyon</i>
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BUREAU V. S.

AUG 11 1968

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8287

Reg. Dist. No. 139

8321

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen, Maryland		c. LENGTH OF STAY IN 1b 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		d. STREET ADDRESS 1436 W. Baltimore Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Earl		First	Middle	Last	4. DATE OF DEATH Month	Day	Year
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 8, 1909	9. AGE (in years lost birthday) 47 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard F. Gettier		14. MOTHER'S MAIDEN NAME Lottie Hensen					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-16-0070		17. INFORMANT Deceased		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 10, 196, to August 31, 1956, that I last saw the deceased alive on August 31, 196, and that death occurred at 3:20A M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Kayn</i>				ADDRESS (Street, city or town, state)		DATE SIGNED August 31, 1956	
PHYSICIAN'S NAME (Type) I. B. Lyon, M. D.		M.D.		Cullen, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. C. Miller</i>		ADDRESS Thurmont MD 21788		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>Kayn</i>	

3. A. 11. 11. 11.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8322 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Hyattstown</i>		c. LENGTH OF STAY IN 1b <i>16</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Roland Ernest Hardy</i>		<i>John</i>	<i>Ernest</i>
4. DATE OF DEATH		Month	Day
<i>August 18 1958</i>		<i>August</i>	<i>18</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>Male</i>		<i>White</i>	<i>Never Married</i>
8. DATE OF BIRTH		9. AGE (in years, last birthday) <i>47 yrs.</i>	
<i>May 7 1909</i>		IF UNDER 1 YEAR <input type="checkbox"/> Months <i>4</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>General Work</i>	
11. BIRTHPLACE (State or foreign country) <i>W. Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>John Edward Hardy</i>		14. MOTHER'S MAIDEN NAME <i>Emma Lee Dello</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr. no. or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>077-10-1457</i>	
17. INFORMANT <i>Mrs Eva Marie Hardy</i>		Address <i>Jaungerle</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>2 minutes</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B. O. Thomas</i>		DATE SIGNED <i>August 18, 1958</i>	
EXAMINER'S NAME (Type) <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 21, 1956</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Hyattstown Methodist Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Hyattstown, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. J. Budette</i>		ADDRESS <i>Hyattstown, Md.</i>	
24a. REC'D BY REGISTRAR <i>REC'D 8/21/58</i>		24b. REGISTRAR'S SIGNATURE <i>H. H. Hendrick</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S

AUG 21 1968

650 1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118289

8323

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BRADDOCK HTS		c. LENGTH OF STAY IN lb 5 MO			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VINDA BONA NURSING HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ROUTE #1			
3. NAME OF DECEASED (Type or print)	First MARIA	Middle TYLER	Last Hayward		
4. DATE OF DEATH	Month Aug	Day 9	Year 1956		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 26 1878		
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT B TYLER			
14. MOTHER'S MAIDEN NAME ELLEN SHRIVER		15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO —		17. INFORMANT Miss ELIZABETH Tyler, Route 1	Address —		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident with right hemiplegia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Hour a. m. p. m.	Month April	Day 19	Year 1955		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) Baltimore	(County) Maryland	(State) MD
21. I certify that I attended the deceased from April , 1955, to August 9 , 1956, that I last saw the deceased alive on Aug 5 , 1956, and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 E. Church Frederick MD 21801					
ACTUAL SIGNATURE Reed Martin	PHYSICIAN'S NAME (Type) Rex R MARTIN		DATE SIGNED 10 Aug 1956		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/11/56	22c. NAME OF CEMETERY OR CREMATORIUM GREENMOUNT	22d. LOCATION (City, town, or county) Baltimore MD		
23. FUNERAL DIRECTOR'S SIGNATURE Harry & Early Co Frederick MD	ADDRESS —	24a. REC'D BY REGISTRAR Elizabeth B. Heck	24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

SURVEY V. L

Aug 11 1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88290

8302

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 7 Years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 322 Adam Road			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
3. NAME OF DECEASED (Type or print) WILLIAM MARTIN HOKE			d. STREET ADDRESS 322 Adam Road		
4. DATE OF DEATH August 13, 1956			Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 20, 1870	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tenant Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Martin Hoke			14. MOTHER'S MAIDEN NAME Amanda Strayer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Mary A. Snyder, 322 Adam Road, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis			INTERVAL BETWEEN ONSET AND DEATH 1 year.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Professional Bldg., Frederick, Md.	(County) Frederick (State) Md.
21. I certify that I attended the deceased from Aug. 11, 1956 to Aug. 13, 1956 , that I last saw the deceased alive on Aug. 11, 1956 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Richard C. Etchison, M.D. ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md. DATE SIGNED 8/14/1956					
PHYSICIAN'S NAME (Type) Dr. R. O. Thomas Jr.			Same as above		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 16, 1956	22c. NAME OF CEMETERY OR CREMATORIUM St. Peter's Peter's Cem.	22d. LOCATION (City, town, or county) Libertytown, Maryland	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			ADDRESS	24a. REC'D BY REGISTRAR DATE 15 Aug 1956	24b. REGISTRAR'S SIGNATURE Elizabeth G. Herb

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8313

CERTIFICATE OF DEATH

118291

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
Frederick MARYLAND		a. STATE	b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	Md.		
Frederick	2 weeks	c. CEMTUR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			
Fred. Memorial Hospital				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
	James	Oliver	Hooper	
4. DATE OF DEATH	Month	Day	Year	
	8	17	1956	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	
male	white		12-22-1878	
9. AGE (In years less birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
77 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
farmer, ret.	farm	Maryland	U. S.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
James Hooper	Florence Gilbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
no			Mrs Lissie Hooper Middletown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	15 days			
DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.	(b)			
	DUE TO			
	(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
19				
21. I certify that I attended the deceased from 8-2-56 1956, to 8-17-1956, that I last saw the deceased alive on 8-17-1956, and that death occurred at 1:45 P.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>J. Elmer Harp</i>	Middletown		8-18-56	
REGISTRAR NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)	(State)
Burial 8-20-1956	Lutheran Cemetery	Middletown	Md.	
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
<i>Bladell Co., Middletown, Md.</i>		DATE 21 Aug 1956	<i>Elizabeth S. Heck</i>	

HOSPITAL ATTENDING PHYSICIAN N: Title 1a requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A MAY 20

1956

PEACE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8324

118292

Reg. Dist. No. 159

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cullen</i>	c. LENGTH OF STAY IN lb 2000 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital	d. STREET ADDRESS 2708 Elliott Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Frank Edward Hoyt	First Frank	Middle Edward	Last Hoyt		
4. DATE OF DEATH August 25, 1956	Month August	Day 25	Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 26, 1899		
9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 50	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor	10b. KIND OF BUSINESS OR INDUSTRY Shipyard	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Hoyt	14. MOTHER'S MAIDEN NAME Margaret Flynn				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-09-8902	17. INFORMANT Deceased	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, inv.					
DUE TO O.O. X					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 5, 1951 , to August 25, 1956 , that I last saw the deceased alive on August 25, 1956 , and that death occurred at 10:10 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <i>J. B. Lyon</i>	M.D.	Cullen, Maryland			August 27, 1956
PHYSICIAN'S NAME (Type) I. B. Lyon, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF August 28, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart Cemetery	22d. LOCATION (City, town, or county) Baltimore County	(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles L. Zeller</i>	ADDRESS <i>901 Franklin St.</i>	24a. REC'D BY REGISTRAR DATE 8/27/56	24b. REGISTRAR'S SIGNATURE <i>W. G. S.</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68293

8304

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
Frederick MARYLAND		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 16 yrs. 30 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 408 N. Bentz Street	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Leslie Franklin	Middle	Last Kefauver
4. DATE OF DEATH	Month August	Day 9	Year 1956
5. SEX	6. COLOR OR RACE Male White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9-1879
9. AGE (In years last birthday) 70 yrs	10. UNDER 1 YEAR Months Years	11. UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles P. Kefauver		14. MOTHER'S MAIDEN NAME Laura Koogle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 217-10-9656	
17. INFORMANT Mrs. Leslie F. Kefauver- Address 108 N. Bentz St. Frederick-Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
2040 DUE TO Leukemia, lymphocytic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure (c) Arteriosclerotic Heart Disease			
INTERVAL BETWEEN ONSET AND DEATH 1/2 plus 3 months 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hypertension 2 years	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1, 1957, to 9 Aug., 1957, that I last saw the deceased alive on 9 Aug., 1957, and that death occurred at 114 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Thomas E. Stone		ADDRESS (Street, city or town, state) 4 W 3rd St Frederick- Maryland DATE SIGNED 8-9-58	
PHYSICIAN'S NAME (Type)		Frederick- Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-11-56	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick- Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son		ADDRESS Frederick- Maryland	24a. REC'D BY REGISTRAR DATE 11 Aug. 1956
			24b. REGISTRAR'S SIGNATURE Elizabeth H. Hech

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2222 2222

AUG 22 1960

115 61

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, should be forwarded to the Chief Medical Examiner's Office along with farm PHM3. Page 5 may be retained for your files.

NO FUNERAL DIRECTOR: Item 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

VS. A1SME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8325 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118294
13

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Airy</i>		c. LENGTH OF STAY IN lb <i>1b</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Penn Shop Road</i>		e. STREET ADDRESS <i>Not Given</i>	
f. NAME OF DECEASED (Type or print) <i>James Clifford Kirkpatrick</i>		4. DATE OF DEATH <i>Aug. 13 1952</i>	Month Day Year
3. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 20, 1930</i> AGE (In years) last birthday <i>22 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Saw Mill</i>	
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Harry Kirkpatrick</i>		14. MOTHER'S MAIDEN NAME <i>Lizzie Roberts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes Korea</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Robert Cosgrove Mt. Airy, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Blow to head</i> DUE TO <i>Impressed fracture of skull</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Fraction base of skull - fracture</i> DUE TO <i>Blow to head - crushed chest</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Automobile accident</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Automobile accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>7:30</i> am. <i>Aug. 13</i> 19 <i>52</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Broadway</i> 20f. (City or town) <i>Mt. Airy</i> (County) <i>Carroll</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B.O. Thomas</i>		DATE SIGNED <i>August 8, 1952</i>	
EXAMINER'S NAME (Type) <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 17, 1956</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Thomas Chapel Cemetery</i>		22d. LOCATION (City, town, or county) <i>Wetzel County, West Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison & Son, Frederick, Maryland</i>		24a. REC'D BY REGISTRAR <i>Elizabeth H. Heck</i> DATE <i>15 Aug 1956</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

BUREAU A.

JUG 16 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8305

CERTIFICATE OF DEATH

118295

Reg. Dist. No. 13

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 20 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 121 Ice Street				d. STREET ADDRESS 121 Ice Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Melvin	Middle Francis	Last Lee	4. DATE OF DEATH August 17-	Month 1956	Day 19	Year 56					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 2- 1898	9. AGE (in years last birthday) 58 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick- Co. Md.		12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME John Lee				14. MOTHER'S MAIDEN NAME Annie Gibson								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO W.W.I 217-01-5885		17. INFORMANT Mrs. Curtis Lee		Address Hopewell - Fred. Co. Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		DUE TO 423.1		INTERVAL BETWEEN ONSET AND DEATH 10 minutes								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b:		DUE TO c:										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy; Chronic Alcoholism						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour 19	Month Aug	Day 1	Year 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frederick, Md.	20f. (City or town) Frederick, Md.	(County) Frederick Co.	(State) Md.				
21. I certify that I attended the deceased from Aug 1, 1956 to Aug 17, 1956 that I last saw the deceased alive on Aug 16, 1956 , and that death occurred at 9 A.M. from the causes and on the date stated above.												
ACTUAL SIGNATURE <i>B.C. Thomas Jr.</i>	ADDRESS (Street, city or town, state) Frederick, Md.		DATE SIGNED Aug. 18, 1956									
PHYSICIAN'S NAME (Type) B.C. Thomas Jr.	Professional Building Frederick- Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 27-56	22c. NAME OF CEMETERY OR CREMATORIUM Hopehill	22d. LOCATION (City, town, or county) Frederick- Co. Md.	(State)								
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III	ADDRESS Frederick, Md.	24a. REC'D BY REGISTRAR Elizabeth G. Heck	24b. REGISTRAR'S SIGNATURE									
VS A15 (4) 1SM 9/55												

BUREAU V. S

AUG 11 1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

108296

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#1		c. LENGTH OF STAY IN 1b About 8 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near McKaig		d. STREET ADDRESS Creagerstown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NELLIE ELIZABETH LONG		4. DATE OF DEATH August 23, 1956	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7 July 1909	9. AGE (in years last birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-keeper		10b. KIND OF BUSINESS OR INDUSTRY Private Family	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Russell C. Long		14. MOTHER'S MAIDEN NAME Naomi Orene Ahalt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk	17. INFORMANT Mrs. Naomi A. Long, RD#1, Thurmont, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address INTERVAL BETWEEN ONSET AND DEATH 7 days?	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation Due to Carbon Monoxide			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 243.1		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Attached Hose to Tail Pipe of Auto	
20c. TIME OF DEATH Month, Day, Year How 10:30 AM Aug. 23, 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 24 Aug 1956	
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 Aug 1956	22c. NAME OF CEMETERY OR CREMATORIUM Utica Cemetery
22d. LOCATION (City, town, or county) Frederick County Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR Elizabeth G. Heib	24b. REGISTRAR'S SIGNATURE
		DATE 34 Aug 1956	

TO MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please excuse the certifying physician writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATMS(E)
SM 9/55

18/10/

9501

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08297

8306

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 100 East Sixth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) SARAH		First	Middle	Last	4. DATE OF DEATH August 30, 1956	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	B. DATE OF BIRTH February 11, 1900	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME Charles E. Esterly.				14. MOTHER'S MAIDEN NAME Margaret Ellis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Roland C. Mackley, Frederick, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 6 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) March 1956 to 8/30 1956, that I last saw the deceased alive on 8/30 1956, and that death occurred at 6:35 P.M., from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) East Church Street, Frederick, Md.		20f. (City or town) Frederick		(County) Maryland	(State) Md.
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ACTUAL SIGNATURE Henry V Chase		ADDRESS (Street, city or town, state) East Church Street, Frederick, Md.							DATE SIGNED 8/31/56
PHYSICIAN'S NAME (Type) Dr. Henry V. Chase		Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 2, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland			(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 4 Sept 1956		24b. REGISTRAR'S SIGNATURE Elizabeth H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Please retain the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU Y. E

SEP 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8307

CERTIFICATE OF DEATH

118298
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
Frederick MARYLAND		Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN TB	b. COUNTY	Frederick			
Frederick	Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Frederick				
229 East Fifth Street		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		229 East Fifth Street				
3. NAME OF DECEASED (Type or print)		First	Middle			
		MARY	IRENE			
4. DATE OF DEATH		Month	Day			
		August	28,			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	November 26, 1898	57	Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housework		Domestic		Maryland		USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Charles E. Redmond		Emma Joy				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		229 East Fifth Street ,
No		(If yes, give war or dates of service)		Mrs. M. Frances Hahn, Frederick, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bronchitis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
		X DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		{ (b)				
		DUE TO				
		{ (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>54</u> , to <u>Aug. 28</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Aug. 28</u> , 19 <u>56</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE <u>Rex R. Martin</u>				M.D. East Church St., Frederick, Md.		8/28/1956
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		Same as above				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 31, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 29 Aug 1956		24b. REGISTRAR'S SIGNATURE Eliza Ruth G. Heck

111 EASY WAY

AUG 30 1956

111 EASY WAY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08299

8327

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville		c. LENGTH OF STAY IN 1b 38 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mountain Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First James	Middle Lee	Last Myers
4. DATE OF DEATH	Month 8	Day 23	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1885
9. AGE (In years last birthday) 71	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13. FATHER'S NAME Patrick Myers	14. MOTHER'S MAIDEN NAME Mollie O'Brine		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 705-12-1695	17. INFORMANT Mrs. Irene Myers, Knoxville, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/23/56 to 8/23/56 , that I last saw the deceased alive on 8/23/56 , and that death occurred at 1 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) X Brunswick, Md 21010			
ACTUAL SIGNATURE <i>E. Lee Myers</i>	DATE SIGNED 8/28/56		
PHYSICIAN'S NAME (Type) Eugenia Burke			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-26-1956	22c. NAME OF CEMETERY OR CREMATORIUM Reformed	22d. LOCATION (City, town, or county) (State) Knoxville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Lee Myers</i>	ADDRESS Brunswick, Maryland	24a. REC'D BY REGISTRAR DATE 8/28/56	24b. REGISTRAR'S SIGNATURE <i>Eugenia Burke</i>

BUREAU U. S.

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8308 Item 9 Film

08300
131

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Frederick</i> Maryland		Md Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Frederick</i>	3 wks.	<i>Mt. Airy</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>Frederick Memorial Hosp</i>	<i>Main St.</i>		
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH
<i>Edgar</i>	<i>C</i>	<i>Rudy</i>	Month 8 Day 4 Year 1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>M</i>	<i>W</i>	<i>9/24/74</i>	9. AGE (in years last birthday) <i>81 82 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Clerk rated</i>		<i>Dry cleaning</i>	<i>Maryland</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Thomas Carlton Rudy</i>		<i>Mary Ellen Lighter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
no		<i>216-09-9037</i>	<i>Mrs. Marvin Alexander, Mt. Airy, MD.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
<i>Pulmonary edema</i>		<i>5 hours</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		<i>Arterosclerotic heart disease with 15 year history</i>	
DUE TO (c) <i>Generalized arterosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<i>Cerebral atrophy, generalized due to arteriosclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		<i>Fracture of skull, laceration of scalp, contusion of brain, hemorrhage in brain, cerebral edema, cerebral atrophy, generalized due to arteriosclerosis</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
Month, Day, Year Hour o.m. p.m.		<i>19</i>	<i>(County)</i> <i>(State)</i>
21. I certify that I attended the deceased from <i>7/14</i> , 1956, to <i>8/4</i> , 1956, that I last saw the deceased alive on <i>8/3</i> , 1956, and that death occurred at <i>9:34 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE		<i>ADDRESS (Street, city or town, state)</i> <i>4 E. Church St 8/4/56</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
<i>Henry V Chase M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>8-7-1956</i>	22c. NAME OF CEMETERY OR Crematory <i>Middletown Reformed</i>
			22d. LOCATION (City, town, or county) <i>Middletown, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. M. Waltz,</i>		ADDRESS <i>Winfield, Maryland</i>	24a. REC'D BY REGISTRAR DATE <i>Aug. 1956</i>
			24b. REGISTRAR'S SIGNATURE <i>Elizabeth L. Head</i>

TO ATTEND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please staple carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
8309

CERTIFICATE OF DEATH

118309
131
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First AGNES	Middle THELMA	Last RUTHERFORD
4. DATE OF DEATH	Month August		Day 1 , Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1900
9. AGE (In years last birthday) 56 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	11. KIND OF BUSINESS OR INDUSTRY Housewife	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Nobel O. Dean	14. MOTHER'S MAIDEN NAME Nettie Virginia McKnight		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Lewis E. Rutherford, Point of Rocks, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arteriosclerosis</i>		2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>8135A N</i>	(County) (State)
21. I certify that I attended the deceased from <i>Aug 1, 1956</i> to <i>Aug 1, 1956</i> , that I last saw the deceased alive on <i>Aug 1, 1956</i> , and that death occurred at <i>8135A N</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. A. Pearce</i>		ADDRESS (Street, city or town, state) <i>4 East Church St., Frederick, Md.</i>	DATE SIGNED <i>8/1/56</i>
PHYSICIAN'S NAME (Type) Dr. Austin A. Pearce		Same as above	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF August 1, 1956	22c. NAME OF CEMETERY OR CREMATORIUM St. Pauls Cemetery	22d. LOCATION (City, town, or county) Point of Rocks, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE <i>3 Aug 1956</i>	
		24b. REGISTRAR'S SIGNATURE <i>Elizabeth J. Heck</i>	

BUREAU Y. S.

AUG 5 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8328

CERTIFICATE OF DEATH

08302

147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frderick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-- Mt. Airy		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-- Mt. Airy	
3. NAME OF DECEASED (Type or print)		First JOHN	Middle H.
4. DATE OF DEATH		Last SHANE	Month August
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 3-21-1903
8. AGED (In years last birthday) 55 yrs.		9. IF UNDER 1 YEAR Months 0	
		10. IF UNDER 24 HRS. Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general	
11. BIRTHPLACE (State or Foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustus Shane		14. MOTHER'S MAIDEN NAME Alice Fritz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no. or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Maude V. Shane,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive + Arteriosclerotic DUE TO Heart Disease		INTERVAL BETWEEN ONSET AND DEATH several years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December, 1952 , to August, 1956 , that I last saw the deceased alive on July 31, 1956 , and that death occurred at 2:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mount Airy, Md DATE SIGNED 8/1/56			
ACTUAL SIGNATURE W.B. Culwell		M.D.	
PHYSICIAN'S NAME (Type) W.B. Culwell			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-4-1956	
22c. NAME OF CEMETERY <input checked="" type="checkbox"/> CEMETARY Druid Ridge		22d. LOCATION (City, town, or county) Pikesville, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
VS A15 (4) 15M 9/55		24a. REC'D BY REGISTRAR DATE	
		24b. REGISTRAR'S SIGNATURE Mrs. Cloris Rumbough	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8329

Item 8 Film

CERTIFICATE OF DEATH

08303
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)		a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Braddock Heights 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Mt. Airy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Vindobona Nursing Home		d. STREET ADDRESS		Park Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle HENRY	Last FRANKLIN	SKEGGS	4. DATE OF DEATH	AUG. 20,	Day 1956	Year
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1878 Sept. 13, 1879		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miller retired		10b. KIND OF BUSINESS OR INDUSTRY Milling		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Henry Skeggs		14. MOTHER'S MAIDEN NAME Virginia Joy							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-01-5616		17. INFORMANT Mrs. Bertha Skeggs, Same		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		acute Cardiac Decomposition				1 day			
4442 X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Chx Myocarditis				2 years.			
DUE TO									
(c) Cardiac Vasculitis Renal Disease						Year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Frederick (State) Md.			
21. I certify that I attended the deceased from Aug 16, 1956, to Aug 20, 1956, that I last saw the deceased alive on Aug 20, 1956, and that death occurred at 9:15 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE H. Lawrence Fahrney M.D.						ADDRESS (Street, city or town, state)		DATE SIGNED 8-20-56	
PHYSICIAN'S NAME (Type) H. LAWRENCE FAHRNEY									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-23-1956		22c. NAME OF CEMETERY OR Crematory Pine Grove		22d. LOCATION (City, town, or county) Mt. Airy, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE 8-23-1956		24b. REGISTRAR'S SIGNATURE Ely. Skeggs			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

115 G 1956

REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8330

CERTIFICATE OF DEATH

08304

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 4 East Church Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First SUSAN	Middle ELIZABETH	Last THOMAS	4. DATE OF DEATH	Month August	Day 14	Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH November 24, 1878	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Cephus M. Thomas				14. MOTHER'S MAIDEN NAME Luretta Schaeffer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-10-1893		17. INFORMANT Mrs. Ross Hollis, Frederick, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senility</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		
						INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick	(County) Md.	(State) Maryland
21. I certify that I attended the deceased from Aug. 12, 1956 to Aug. 14, 1956 , that I last saw the deceased alive on Aug. 14, 1956 , and that death occurred at 8:00P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) M.D. East Church Street, Frederick, Md.								DATE SIGNED 8/15/56
ACTUAL SIGNATURE <i>Rex R. Martin</i>		Same as above						
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin								
22a. BURIAL, CREMATION: REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Elizabeth H. Heck		24b. REGISTRAR'S SIGNATURE Elizabeth H. Heck		
				DATE 16 Aug. 1956				

BUREAU V. S.

AUG 20 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8331

CERTIFICATE OF DEATH

Reg. Dist. No.

108305
134

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eminitsburg.		c. LENGTH OF STAY IN 1b 18 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eminitsburg,		d. STREET ADDRESS Federal Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Federal Ave.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harvey	Middle Jacob	Last Warner	4. DATE OF DEATH Month August	Month 2	Day 19	Year 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH May 24th 1883	9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Carroll Co. Maryland		11. BIRTHPLACE (State or foreign country) United States					
13. FATHER'S NAME Benjamin F. Warner				14. MOTHER'S MAIDEN NAME Emma A. Eyler					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 20-18-2266		17. INFORMANT Lloyd G. Ollier		Address East Maine St. Eminitsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized Arteriosclerosis. (c)				INTERVAL BETWEEN ONSET AND DEATH minutes					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 23, 1953 , to July, 1956 , that I last saw the deceased alive on July, 1956 , and that death occurred at 47 M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Eminitsburg, Md.	
ACTUAL SIGNATURE Charles R. Williams		DATE SIGNED Aug 2, 1956							
PHYSICIAN'S NAME (Type) CHARLES R. WILLIAMS MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Keysville Cemetery		22d. LOCATION (City, town, or county) (State) Keysville, Carroll Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison				ADDRESS Eminitsburg, Md.					
				24a. REC'D BY REGISTRAR DATE Aug 5 E.		24b. REGISTRAR'S SIGNATURE A. H. Hendrick			

RECEIVED
AUG 5 1956

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118306

8332

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First MARY	Middle JANE	Last REBECCA WHIPP	4. DATE OF DEATH Month Day Year August 23, 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 20 Sept 1858	9. AGE (in years last birthday) 97 yrs	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME David Myers			14. MOTHER'S MAIDEN NAME Susan Specht		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. J. Raymond Corun, Jefferson, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i>			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.		
40 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 7 N. Market St., Frederick, Md. DATE SIGNED 8/23/56					
ACTUAL SIGNATURE <i>H. F. Kline</i>					
PHYSICIAN'S NAME (Type) H. F. Kline, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 25 Aug 1956		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) Frederick, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR DATE 34 Aug 1956		
			24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8310

CERTIFICATE OF DEATH

118308
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 11 wk.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 108 W. All Saints Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 W. All Saints Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ethel	Middle 	Last Williams	4. DATE OF DEATH August 11 1956	Month August	Day 11	Year 1956
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22-1903	9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick, Co.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Tyler				14. MOTHER'S MAIDEN NAME Vergie Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Daniel Williams	Address 108 W. All Saints St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Uterus</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO							
INTERVAL BETWEEN ONSET AND DEATH Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
July 21, 1956							
21. I certify that I attended the deceased from <i>July 21, 1956</i> , to <i>Aug. 11, 1956</i> , that I last saw the deceased alive on <i>Aug. 9, 1956</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED							
ACTUAL SIGNATURE <i>Robert S. Turner Jr.</i> M.D.							
PHYSICIAN'S NAME (Type) R.S.Turner Jr. 7 East Church Street Frederick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 14, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Bartonsville		22d. LOCATION (City, town, or county) (State) Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III		ADDRESS Frederick, Md.		24a. REC'D BY REGISTRAR DATE 14 Aug 1956		24b. REGISTRAR'S SIGNATURE Elizabeth L. Hicks	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8311

CERTIFICATE OF DEATH

08309

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK Memorial Hospital</u>		d. STREET ADDRESS <u>Plot #1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Philip Joseph Wolfe Jr.</u>		First <u>Philip</u>	Middle <u>Joseph</u>
		Last <u>Wolfe Jr.</u>	4. DATE OF DEATH <u>August 10 1956</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>August 9, 1956</u>		9. AGE (In years lost birthday) yrs. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>Philip Joseph Wolfe Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Clara Elaine Baugie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mother - Mrs. Clara Wolfe Dickerson</u>		Address <u>Rt. #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO <u>761.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fetal atelectasis</u> DUE TO (c) <u>Placenta praevia marginalis</u> DUE TO <u>Maternal</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Frederick Md.</u>		20f. (City or town) (County) (State) <u>Fredrick, MD</u>	
21. I certify that I attended the deceased from <u>Aug. 9, 1956</u> , to <u>Aug. 10, 1956</u> , that I last saw the deceased alive on <u>Aug. 10, 1956</u> , and that death occurred at <u>11:57 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B.O. Thomas Jr.</u>		ADDRESS (Street, city or town, state) <u>Fredrick, MD</u>	
PHYSICIAN'S NAME (Type) <u>B.O. Thomas Jr.</u>		DATE SIGNED <u>Aug. 10, 1956</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>8/12/56</u>		22b. DATE THEREOF <u>8/12/56</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Bells Chapel</u>		22d. LOCATION (City, town, or county) <u>Dickerson, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR DATE <u>Aug. 14, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Ely G. Beck</u>	

DEPARTMENT OF DEFENSE
COMMITTEE ON SECURITY

BUREAU V.

AUG 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08310

Reg. Dist. No.

8333

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be rejoined to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen, Maryland		c. LENGTH OF STAY IN 1b 42 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. #2, Boonsboro, Washington County, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				d. STREET ADDRESS 218-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Harry	Middle P.	Last Zulauf	4. DATE OF DEATH August	Month Day Year 27 19 56
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1900	9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dagmar Hotel		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Harry C. Zulauf		14. MOTHER'S MAIDEN NAME Mary Pasquay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-07-7824		17. INFORMANT Address Deceased	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism				INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
DUE TO 0028					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Thrombophlebitis				2 weeks	
DUE TO 0028				4 months	
(c) Pulmonary Tuberculosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1956 , to August 27, 1956 that I last saw the deceased alive on August 27, 1956 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ADDRESS ACTUAL SIGNATURE I. B. Lyon				DATE SIGNED August 27, 1956	
PHYSICIAN'S NAME (Type) I. B. Lyon, M.D.		M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
				22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Saunders Baltimore, Md.		ADDRESS R.S.		24a. REC'D BY REGISTRAR DATE 5/28/56	
				24b. REGISTRAR'S SIGNATURE I. B. Lyon	

CERTIFICATE OF DEATH

NAME

ADDRESS

PHONE

AGE

SEX

RACE

RELIGION

EDUCATION

EMPLOYMENT

DEATH DATE

TIME

CAUSE

DEATH PLACE

DEATH NUMBER

RECEIVED
FBI
HONOLULU

AUG 30 1956